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ABSTRACT

Although group treatment techniques have gained substantial support for their use in the remediation of the effects of childhood sexual abuse (CSA), little empirical research has been performed on this subject. So as to assess the status of this treatment form, a review of the empirical research on group treatment of CSA is presented in this report. Following a synopsis of the methodological issues, such as sampling, instruments used, and data analyses, results of the review are grouped according to the focus of the research efforts: the characteristics of clients who complete group, the effectiveness of time-limited groups, the relative importance of Yalom's curative factors, and the impact of specific group interventions. Suggestions for further research in this area include the following: use of controlled studies; use of larger samples (including both men and women of diverse ethnic minority groups and varied socioeconomic background); further investigation of specific therapeutic techniques; review of treatment length and format; and exploration of the complementary roles of group and individual therapy for adult survivors. Clinical implications of the findings are also discussed. Contains approximately 175 references. (RJM)

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GROUP TREATMENT OF ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE: A LITERATURE REVIEW

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Karen Ledbetter Smith

May, 1997

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GROUP TREATMENT OF ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE: A LITERATURE REVIEW

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ABSTRACT

GROUP TREATMENT OF ADULT SURVIVORS OF CHILDHOOD SEXUAL ABUSE: A LITERATURE REVIEW

by

Karen Ledbetter Smith

Although the group treatment modality has gained substantial support for its use in the remediation of the effects of childhood sexual abuse (CSA) little empirical research has been performed on this subject. This review focuses upon the empirical research on group treatment of CSA which exists to date.

Studies have investigated the characteristics of clients who complete group, the effectiveness of time-limited groups, the relative importance of Yalom's (1975) curative factors, and the impact of specific group interventions. Suggestions for future research include: (a) the use of controlled studies; (b) the use of larger samples which include both men and women of diverse ethnic minority groups with varied socioeconomic backgrounds; (c) further investigation of how specific therapeutic techniques, treatment length and format, and group member similarity affect treatment outcome; and (d) exploration of the complementary roles of group and individual therapy for adult survivors.

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Group Treatment of Adult Survivors of Childhood Sexual Abuse: A Literature Review

Introduction

As recently as 20 years ago, sexual abuse was regarded as a relatively uncommon problem. However, as more research was conducted in the late 1970s, reports of sexual abuse increased at a much more rapid rate than reports of other forms of abuse (Finkelhor, 1979). Accompanying the rise in reported cases, the problem of sexual abuse has received increasing coverage by the press and media. Numerous books, films, major network documentaries, newspaper articles, and well-publicized trials have served to heighten public awareness of the problem (Finkelhor, 1984).

Prevalence

The exact prevalence of CSA (Childhood Sexual Abuse) remains unknown and estimates continue to vary. In the late 1970s to mid 1980s, Finkelhor (1979) and Russell (1986) estimated that one out of every four women (25%) and one out of every ten men (10%) were sexually abused before age 18. However, Stein, Golding, Siegel, Burnam, and Sorenson (1988) reported that in a community

random sample of 3,132 men and women, only 6.8% of the women and 3.9% of the men responded affirmatively to having a history of CSA.

Beitchman et al. (1992) cautioned that "the true prevalence of a given condition can only be obtained from a random, representative sample" (p. 102). The incidence rate obtained in clinical or nonrandom representative samples can deviate from the true prevalence rate depending upon the specific group which is being sampled. To date, Finkelhor, Hotaling, Lewis, and Smith (1989) have conducted the only study using a random, representative sample. In a national survey of 2,630 women and men, they found that 27% of the women and 16% of the men respondents reported a history of CSA.

The incidence of CSA in psychiatric populations is recognized as being much higher than the incidence in the general population. Carmen, Rieker, and Mills (1984) found that 43% of a psychiatric inpatient population had a history of sexual or physical abuse. Bryer, Nelson, and Miller (1987) studied a consecutive series of female patients admitted to a private psychiatric hospital and found that 44% had been victims of CSA. In their review of the literature, Hutchings and Dutton (1993) reported that the incidence rate for CSA in studies of inpatient populations has ranged from 37.9% to 62% for women and 16% to 26% for men.

While the true incidence of CSA in the general population and among psychiatric populations remains open for further study, it is clear that CSA is a

significant issue for many individuals who seek psychological services. Addressing the long-term effects of this childhood experience is often the focus of therapeutic intervention.

Long-Term Effects

The long-term effects associated with CSA have been well documented and reviewed in the literature (Beitchman et al., 1992; Browne & Finkelhor, 1986; Cahill, Llewelyn, & Pearson, 1991; Finkelhor, 1990; Green, 1993). Those symptoms supported by both clinical and empirically-based studies include depression; anxiety; tension and fear; low self-esteem; feelings of stigmatization; difficulty with intimate, dyadic relationships; sexual maladjustment and marital disruption; and vulnerability to revictimization (Briere & Runtz, 1988; Browne & Finkelhor, 1986; Finkelhor, et al., 1989, 1990; Hunter, 1991; Russell, 1986; Stein et al., 1988). Other symptoms noted include suicidality (Briere, Evans, Runtz, & Wall, 1988; Peters & Range, 1995), dissociation (DiTomasso & Routh, 1993; Roesler & McKenzie, 1994), body-image incongruities (Hunter, 1991), higher rates of drug and alcohol abuse (Stein et al., 1988), decreased religiosity (Finkelhor et al., 1989), somatization and absenteeism (Bendixen, Muus, & Schei, 1994; Briere & Runtz, 1988), and homosexuality and identity confusion (Hunter, 1991; Runtz & Briere, 1986).

During the last decade, sexual abuse of children and its long-term effects have been more widely acknowledged and addressed than ever before. Not surprisingly, mental health professional are increasingly having to deal with treatment issues for this population. Thus, questions of what type of treatment is helpful and what aspects of treatment are beneficial are important to address.

Group Treatment

The group treatment modality has gained substantial support for its use in the remediation of the effects of CSA. In fact, many clinicians contend that group therapy may be the treatment of choice due to the group format's profound impact upon issues such as isolation, stigma, and secrecy (Agosta & Loring, 1988; Alexander & Follette, 1987; Courtois, 1988; Forward & Buck, 1978; Gil, 1988; Goodman & Nowak-Scibelli, 1985; Herman & Schatzow, 1984; Jehu, 1988; McEvoy, 1990; Sgroi & Bunk, 1988; Zimpfer, 1987).

The literature reflects a considerable array of theoretical information regarding the treatment of the long-term effects of CSA. Based upon clinical experience, a number of authors have provided recommendations and technical parameters for leading effective short-term (Barney, 1990; Cole & Barney, 1987; Deighton & McPeek, 1985; Goodman & Nowak-Scibelli, 1985; Knight, 1993) and long-term (Hall, 1992; Mennen & Meadow, 1992; Kreidler & Fluharty, 1994) survivors' groups.

Although the clinical literature is replete with books and articles on treating adult survivors of CSA, there is little empirical research on this subject. In fact, there has been only one controlled outcome study investigating the effectiveness of two different formats of group therapy for this population (Alexander, Neimeyer, Follette, Moore, & Harter, 1989). One additional study (Apolinsky & Wilcoxon, 1991) had a control group for evaluating the effects of a specific group intervention. None of the empirical studies have included men in their samples. This review will focus upon the empirical research on group treatment of adult survivors of CSA which exists to date.

Methodological Issues

Psychotherapy researchers have achieved consensus on a number of principles and methods as standards for assessing the internal and external validity of treatment research. These principles are methodological guidelines for reducing potentially contaminating and confounding influences.

Several methodological issues can be identified in the research conducted to date regarding group treatment of adult survivors of CSA. Following is a description of issues regarding: (a) sampling procedures, (b) the reliability and validity of instruments, (c) standardized procedures, and (d) data analyses and reporting.

Sampling

There are several sampling issues that affect the generalizability of results from the studies reviewed. These areas include providing inadequate demographic information about the sample, employing small samples, and using nonrepresentative samples in terms of gender and race.

Four of the eleven studies reviewed did not provide demographic information about their sample or provided inadequate information to evaluate the generalizability of their results. Wheeler, O'Malley, Waldo, Murphey, and Blank (1992) reported that all of the study participants had experienced father-daughter incest, but gave no further information about group member characteristics. All of the women in the sample used by Fisher, Winne, and Ley (1993) were Caucasian and diagnosed with major depression, but information about age, marital status, and abuse characteristics was not reported. Threadcraft and Wilcoxon (1993) stated that their participants "varied," and Bonney, Randall, and Cleveland (1986) reported that their group was "homogeneous" with regard to demographic characteristics. The remaining studies provided detailed information about their participants which enables the results to be applied to the appropriate populations.

Some of the studies reviewed used very small samples (Bonney et al., 1986; Threadcraft & Wilcoxon, 1993; Wheeler et al., 1992). Their samples ranged in size from 7 to 10 participants and included women from only one therapy group. More

adequate samples, ranging in size from 30 to 148, were used in the remaining studies. However, two studies (Alexander et al., 1989; Apolinsky & Wilcoxon, 1991) conducted multiple analyses of data with small subsamples. For example, although 65 women were included in Alexander et al.'s total sample, only 7 individuals comprised the dropout group which was compared to therapy completers. The use of small samples severely limits the generalizability of study results to the population of adult survivors. Also, because multiple statistical tests were computed, there is a risk of spurious significant findings.

The issue of representativeness of the sample was also prominent in the studies reviewed. All of the empirical studies on group therapy with adult survivors to date have included only women in their treatment groups. Therefore, the results of these studies can be applied only to female survivors. Also, none of the study samples was representative regarding its racial composition. Caucasian women were used exclusively by Apolinsky and Wilcoxon (1991), Bonney et al. (1986), Fisher et al. (1993), and Wheeler et al. (1992). The largest ethnic minority representation was in the Follette, Alexander, and Follette (1991) study which included 24% African-American participants. Therefore, results of current research are most appropriately generalized to female Caucasian survivors.

Instruments

Beutler and Hill (1992) stated that measurements in psychological research should be based on instruments for which there exists independent evidence of reliability and validity. Roberts and Lie (1989) assessed participant functioning using the Self-Assessment Scale which has unknown reliability. Therefore, the conclusions drawn in this study are questionable.

Several studies provided brief descriptions of the measures used to assess group member functioning, but did not report specific information about their reliability or validity (Carver, Stalker, Stewart, & Abraham, 1989; Fisher, et al., 1993; Follette et al., 1991). Although some of these measures are used frequently in psychotherapy research and practice (e.g., Beck Depression Inventory; Millon Multiaxial Clinical Inventory-editions I & II; and Symptom Checklist-90-R), others may not be as familiar to clinicians (e.g., Zung Self Rating Depression Scale; Texas Social Behavior Inventory; and Social Adjustment Scale). Unknown or questionable reliability and validity information makes interpretation and application of study results difficult. In addition, comparability of results to other studies is compromised.

Procedures

Lack of a control group in outcome research limits the interpretation of pretreatment to posttreatment changes because they could be caused by the effects

of other variables (e.g., maturation or retesting) rather than by the group treatment. Only two of the eight studies reviewed used control groups to evaluate treatment efficacy. Alexander et al. (1989) compared treatment outcomes for participants in an interpersonal transaction group and a process-oriented group to a wait list condition. Apolinsky and Wilcoxon (1991) evaluated participant improvement in two groups which used the same treatment model except that one included symbolic confrontation. Because a control group was used in these studies the findings can be attributed to the intervention.

Concurrent individual therapy was a confounding variable in several of the studies (Carver et al., 1989; Hazzard, Rogers, & Angert, 1993; Herman & Schatzow, 1984; Roberts & Lie, 1989). This severely limits the ability to attribute improvement to the group intervention alone. Also, the studies which included 6-month follow-up evaluations did not preclude group members from obtaining additional treatment in the intervening time (Alexander et al., 1989; Herman & Schatzow, 1984; Roberts & Lie, 1989). The relationship between previous group treatment and participant functioning at the 6-month follow-up cannot be definitively ascertained because of the potential impact of additional treatment or other intervening variables.

Although group treatment was the dependent variable in most of the studies, there was considerable variation in the amount of description provided about the

actual intervention. Some studies furnished very detailed accounts of the format and content of each session (Apolinsky & Wilcoxon, 1991; Herman & Schatzow, 1984; Roberts & Lie, 1989). Others offered little or no information about the treatment process (Carver et al., 1989; Fisher et al., 1993). As a result, it is not only difficult to compare findings, but also to replicate the studies as well.

Data Analyses and Reporting

A methodological issue which affects the ability to compare results is the lack of consistency in the treatment of data across studies. This problem was particularly evident in the three studies of curative factors which essentially used the same research design (Bonney et al., 1986; Randall, 1993; Wheeler et al., 1992). Wheeler et al. reported the total Q-sort points for each of the factors; Randall reported means; and Bonney et al. reported ordinal ranking only. As a result, there is no consistent way of accurately comparing the findings between or among studies. A difference of two places in the ranking of one study could actually be the same as five or six places in another. These diverse methods of reporting may lead to assumptions of comparable results that are not valid or to differences that are exaggerated.

Another common methodological issue in psychotherapy outcome research is the way in which data regarding treatment efficacy is analyzed and reported. Practitioners have often complained about the irrelevance of most psychotherapy

research for clinical practice (Jacobson, Follette, & Revenstorf, 1984). Two areas which have been criticized include (a) the exclusive reliance on group means and statistical significance tests in evaluating treatment effects, and (b) the corresponding deemphasis on data which highlight variability and clinical significance. Without some information regarding variability of outcome the consumer has no way of estimating the likelihood that a given individual will benefit from therapy.

Measuring treatment efficacy only in terms of statistical significance is inadequate at best. Many have begun to advocate clinical significance as a criterion for evaluating outcome research, but little consensus regarding its definition has been reached (Beutler & Hill, 1992). As yet, no conventions have been developed to define the conditions under which an individual is to be classified as improved.

All of the studies on group therapy outcome for survivors of CSA, except Fisher et al. (1993), relied exclusively on statistical significance in reporting treatment efficacy. Roberts and Lie (1989) was the only study to discuss variability of outcome. Failure to address the issues of clinical significance and individual variability limits the usefulness of the research for clinicians.

Empirical Research

The research on group treatment has focused on characteristics of both clients and group interventions. Studies have investigated characteristics of clients who complete group, the effectiveness of time-limited groups, the relative importance of Yalom's (1975) curative factors, and the impact of various specific group interventions.

Characteristics of Group Completers

The problem of group attrition comprises one of the central, and often unattended, issues in therapy efficacy. The issues of treatment evasion or early departure is particularly relevant for survivors, whose initial access to therapy is often highly constrained by their social, economic, and clinical disadvantages (Fisher et al.,1993). In addition, outcome studies typically evaluate treatment effectiveness based on the results of the group as a whole. Even in group therapy formats characterized by improvement of the majority of the participants, variability in outcome suggests the importance of identifying individual factors that predict completion of and response to treatment.

Several studies have examined factors which distinguish adult survivors who complete a group therapy program from those who drop out (e.g., Alexander et al., 1989; Fisher et al., 1993; Follette et al., 1991; Hazzard et al., 1993). Client

characteristics which affect improvement over the course of group therapy also have been investigated (Follette et al., 1991; Hazzard et al., 1993).

Fisher et al. (1993) examined client factors which differentiated women who completed a 6-month therapy group for survivors of CSA from those who dropped out of the group. Prospective participants included 103 depressed women who were self-referred or referred by mental health professionals for treatment at a community mental health center. From the initial interview or intake forms, sixty-four women were identified as having a history of CSA.

This subgroup of 64 sexual abuse survivors was offered the opportunity to participate in a group treatment program; 54 women chose to do so. The only criteria for group participation was a diagnosis of major depression and a history of CSA. This study defined sexual abuse as "sexual contact between a child (under 12 years) and a postpubertal person at least 5 years older, or any sexual contact between a child and an adolescent in which force is used" (Fisher, et al., 1993; p. 618). Specific demographic information about the 54 study participants was not provided.

The Millon Clinical Multiaxial Inventory (MCMI; Millon, 1983) was administered prior to the beginning of group to assess pretherapy adjustment. Seven groups of 5 to 10 members each met weekly for a 6-month group therapy

program. Information about group format, content, and facilitators was not provided.

The 32 individuals who completed therapy were compared to the 22 individuals who dropped out in terms of demographic characteristics, abuse history, and pretherapy adjustment. Completers were more likely than dropouts to be unmarried, to be high school graduates, and to have an employment history. In addition, they were less likely to have experienced physical abuse as children and were more likely to have been sexually abused by numbers of offenders both within and outside the family. The authors also suggested that the dropout group appeared to be more entrenched in a current abusive relationship, although no specific data was reported regarding this issue.

Overall, both groups presented with similar patterns of MCMI score peaks. The completer group had a higher overall pattern of psychopathology, with means in the clinically significant range (> 70) on 8 scales, compared with 6 scales in that range for the dropout group. Therapy completers showed more pronounced clinically significant dependent features ($p < .027$) at the outset of treatment. Dropouts were more narcissistic ($p < .028$), antisocial ($p < .006$), and paranoid ($p < .007$), but their mean scores on these scales were not in the clinically significant range. The authors conclude that the dropouts' personality profile looked less trusting, more self-involved, less capable of bonding, and angrier

compared to the completers who were more dependent and in greater overall distress initially.

Follette et al. (1991) conducted a study to identify variables that correlate with long-term adjustment before therapy, and to examine the influence of those variables on incest survivors' response to group therapy. They specifically investigated the effects that demographic variables, abuse characteristics, family characteristics, and initial levels of disturbance have on pretreatment adjustment and response to group therapy.

Participants were recruited through newspaper ads and mailings to local therapists. Women were assessed during a screening interview. Those with severe suicidal ideation, severe substance abuse, and psychosis were excluded from participation.

The sample included 65 women who had been abused by father figures. Their ages ranged from 23 to 55 years ($\underline{M}$ = 36). The majority of participants were Caucasian (76%), while the remaining were African-American (24%). Of these women, 36% were married, 39% were single, and 20% were divorced. More than half of the participants reported experiencing intercourse (52%) during the abuse, 15% experienced oral-genital contact, and 33% reported fondling with no other sexual contact. The duration of abuse ranged from 1 month to 16 years ($\underline{M}$ = 7

years). Abuse onset was categorized as before age 6 (33%), from 6 to 11 (50%), and after age 11 (17%).

Six measures were used to assess pre- and post-group functioning including the Social Adjustment Scale (SAS; Weissman & Paykel, 1974), Beck Depression Inventory (BDI; Beck, Steer, & Garbin, 1988), Symptom Checklist-Revised (SCL-90-R; Derogatis, 1983), Family Adaptability and Cohesions Scales (FACES-II; Olson, Russell, & Sprenkle, 1983), Traditional Family Ideology Scale (TFI; Levinson & Huffman, 1955), and Locke-Wallace Marital Adjustment Scale (MAS; Locke & Wallace, 1959). An interviewer administered the SAS which was videotaped for later coding. All other instruments were self-report measures.

Participants were randomly assigned to either an interpersonal transaction (IT) group or a process-oriented group. The IT group consisted of weekly dyadic interactions in which members discussed topics which were relevant to their incest experience. The process group was based upon the treatment presented by Yalom (1975). Specific topics discussed were left to the discretion of the group members and ranged from abuse-related issues to more current stressors.

Both groups met for 10 weekly 90-minute sessions led by two female advanced doctoral students. Group leaders were closely supervised by two licensed clinical psychologists who viewed video tapes to ensure the integrity of each treatment condition.

The results of the study indicate that poorer pretreatment adjustment as measured by the SAS was associated with less education, shorter periods of abuse, more psychological distress (SCL-90-R), more depression (BDI), and lower marital satisfaction (MAS). The MAS score followed by the BDI score predicted pretreatment adjustment. The partial correlations of these two variables were -.44 ($p < .02$) and .38 ($p < .04$), respectively.

In evaluating response to treatment, better therapy outcome was associated with more education, being single, having been fondled only, and having lower pretreatment MAS and BDI scores. Previous therapy was also associated with better outcome in the process group, but not in the IT group. Level of education with a partial correlation of -.49 ($p < .005$) followed by pretherapy BDI scores with a partial correlation of .39 ($p < .02$) predicted therapy outcome.

Using the same sample, Alexander et al. (1989) analyzed the client characteristics of those who completed group compared to those who did not. Of the 65 survivors who began group treatment, a total of 7 women failed to complete the 10-week program. These women did not differ significantly from those who completed group with respect to age, education, marital status, or race. They also did not differ significantly from group completers in abuse characteristics or on the BDI, the SAS, or the SCL-90-R. However, they reported significantly less

fearfulness on the Modified Fear Survey (MFS; Veronen & Kilpatrick, 1980) at the initial evaluation ($p < .05$).

Hazzard et al. (1993) examined the relationship between abuse characteristics and initial symptomatology, length of participation, and improvement over the course of a year-long group treatment. They also assessed the degree of pretreatment to posttreatment improvement using several measures of psychological adjustment.

Participants were recruited through newspaper announcements and therapist referrals. In order to participate, survivors had to inform their spouse about both the abuse and their involvement in group therapy. Exclusion criteria were similar to those used by Follette et al. (1991).

The sample included 148 women aged 18 to 53 ($M = 35.4$). Most of the participants were Caucasian (92%), while the remaining 8% were Asian, Hispanic, or African-American. In terms of abuse characteristics, 65% were abused by a parent figure and 54% experienced intercourse. The duration of abuse averaged 6.8 years. Many of the participants were in concurrent individual therapy during the course of the year-long group.

Participants were assessed using five standardized measures prior to the beginning of group and again 3 weeks before group ended. These instruments included the Locus of Control Scale (LOC; Nowicki & Duke, 1974); the Sexual

Symptom Checklist (SSC; Maltz & Holman, 1987); the Index of Self-Esteem (ISE; Hudson, 1982); the Trauma Symptom Checklist (TSC-33; Briere & Runtz, 1989); and the Symptom Checklist (SCL-90-R; Derogatis, 1983).

The study included 22 time-limited, closed membership groups of 4 to 10 participants. All groups met for 90 minutes weekly over the course of a year. Groups were led by one or two masters or doctoral level mental health professionals who had participated in a 2-day training workshop. Most groups were led by female therapists; however, two groups were led by male-female cotherapist teams. The 37 group leaders attended monthly 2-hour supervision meetings with leaders of six to eight other groups.

The group format followed Yalom's (1975) basic model of process-oriented group psychotherapy in which group members develop trust during the group formation phase, integrate affect and build skills during the growth phase, and deal with separation and loss issues during the termination phase. The content of the treatment was based on Courtois' (1988) conceptualization of the consequences of sexual abuse, goals of treatment, and therapeutic strategies.

In examining the relationship of abuse characteristics to initial symptomatology, trauma-related symptoms (TSC-33 Total) were associated with the number of abusers ($p < .01$). Dissociation (TSC-33-D) was related to the age at which the abuse started ($p < .05$), with survivors whose abuse began as

preschoolers being more dissociative than survivors who abuse began at age 6 or older. Overall psychological distress (PSDI) on the SCL-90-R was related to type of abuse ($p < .001$), with more intense symptoms reported by subjects who had experienced intercourse. Duration of abuse, relationship to the perpetrator, number of perpetrators, presence of violence, disclosure, and others' reaction to disclosure were not found to be significantly associated with level of initial distress.

Of the 148 group members who began treatment, 102 women who participated for 10 months or more were considered completers. Several variables were examined in order to evaluate whether or not they were associated with treatment completion. Demographic variables included age, ethnicity, and marital status. Abuse characteristics including relationship to the perpetrator, number of abusers, type of abuse, and duration of abuse were also analyzed. Group process factors also served as independent variables including similarity of group members' abuse histories, initial level of trust in the group, and group leaders' survivorship status. Prior symptomatology and treatment variables included drug abuse history, previous individual or group therapy, psychiatric hospitalization, and prescores on the symptomatology variables.

The only significant result from the analyses was that persons without a history of psychiatric hospitalization were more likely to complete treatment. The majority of survivors who had never been hospitalized completed treatment (77%),

majority of survivors who had never been hospitalized completed treatment (77%), while only 42% of survivors who had been hospitalized stayed in treatment at least 10 months. The authors suggested that group completion was not readily predictable by the variables investigated in this study with the exception of previous hospitalization.

Pretreatment and posttreatment data were available for only 78 of the 102 participants who completed therapy. No analysis was provided regarding potential differences between individuals for whom data was available and those for whom it was not. Results of pretreatment-posttreatment analyses indicated that participants significantly improved in the clinically desired direction on each of the symptomatology variables. Following the group intervention, participants showed more internal locus of control ($p < .001$), decreased sexual problems ($p < .001$), better self-esteem ($p < .001$), reduced trauma-related symptomatology ($p < .01$), and less overall psychopathology ($p < .01$).

The SCL-90-R psychological distress (PSDI) score was used to measure overall improvement over the course of the group. Participants who demonstrated greater decreases in overall psychopathology as measured by the PSDI were more likely to be Caucasian, have no history of drug abuse, have participated in previous therapy, and have been in a group whose members had similar abuse histories.

The findings of Hazzard et al. (1993) are similar to those of Alexander et al. (1989) and Carver et al. (1989) who found that completers did not differ from dropouts with respect to demographics, abuse characteristics, and initial distress. However, the results are inconsistent with those of Fisher et al. (1993) who found that marital status and number of abusers were related to treatment completion. Both Carver and Hazzard et al. concluded that previous hospitalization was associated with failure to complete group treatment.

The results of Hazzard et al. (1993) also differed from those of Follette et al. (1991) who concluded that marital status, initial distress, and type of abuse were related to change over time. It is possible that the length of treatment (1 year versus 10 weeks) was sufficient to overcome the impact of those variables on treatment outcome. One congruent finding between the two studies was the positive relationship between previous therapy and group treatment outcome.

Level of education was evaluated by Fisher et al. (1991) and Follette et al. (1993). Both studies found that participants with less education were more likely to drop out of treatment and to have poorer outcomes in group treatment. This variable needs to be evaluated further to determine its contribution to treatment outcome.

Effectiveness of Time-Limited Groups

An additional group of studies examined the effectiveness of time-limited groups in reducing symptomatology of survivors of CSA (Carver et al., 1989; Herman & Schatzow, 1984; Roberts & Lie, 1989). These therapy groups typically lasted 10 to 15 weeks and often had a structured approach for each session.

Herman and Schatzow (1984) used participants' responses to an evaluation questionnaire to examine a model of time-limited group treatment for incest survivors. They suggested several advantages of the time limit in a short-term group therapy model: (a) it facilitates bonding and diminishes members' resistance to sharing emotionally important material, (b) it offers a structure within which the regressive aspect of the treatment can be contained, and (c) it encourages focus on the common theme of incest, with minimum attention to present differences and interpersonal conflicts within the group.

A total of 50 women referred by private practitioners and local agencies were evaluated as prospective group members. In order to participate, survivors were required to have positive feelings about group participation, be functioning well in day-to-day life, and be in concurrent individual therapy. Of the 30 women selected to participate, 28 completed the program.

The age of group members ranged from 16 to 53. Most of the survivors were single, Caucasian, and were from working or middle class families. Over

A total of five groups with 5 to 7 members each met weekly for 90 minutes during a 10-week period. Groups were conceptualized as "situation-transition" groups as described by Schwartz (1975) in which factual information, social support, and an opportunity for emotional interaction with peers was provided. They were led by two cotherapists who used a relatively informal, active, and supportive leadership style. Interpretation of group dynamics, individual resistances, or unconscious material was avoided.

Approximately 6 months following the termination of the groups, the 28 completers were sent an evaluation questionnaire which asked: (a) what they liked least and best about the group, (b) what they suggested about ways to improve the group, and (c) how they had changed as a result of the group. In addition, they were asked to rate aspects of their lives as better, worse, or about the same. The areas rated included work, friendships, relationships with family members, intimate relationships, feelings about sex, feelings about themselves, and ability to protect themselves. The return rate on the questionnaires was 71%.

Respondents unanimously viewed contact with other incest victims as useful. Criticisms generally focused on the session time limit. Improved self-esteem was reported by 85% of respondents, followed by reduced feelings of shame and guilt (80%), improved ability to protect themselves (80%), and

self-esteem was reported by 85% of respondents, followed by reduced feelings of shame and guilt (80%), improved ability to protect themselves (80%), and decreased feelings of isolation (75%). Relationships with others, work, and sex did not show consistent improvement at follow-up.

Roberts and Lie (1989) evaluated another time-limited group model for treatment of sexual abuse survivors. They specifically investigated the effectiveness of the intervention for alleviating depression and improving overall psychosocial, physical, and sexual functioning. They also examined participants' satisfaction with the group structure, content, and process.

Participants were referred by their individual therapists, friends, relatives, or other helping professionals. Individuals who were incoherent, delusional, or actively suicidal were excluded from group participation. Members were strongly encouraged to be in concurrent individual therapy.

A total of 53 women (49 Caucasian, 2 Asian, and 1 Hispanic) participated in the study. Their ages ranged from 19 to 48 ($\underline{M}$ = 32). More than half of the women were single, about one quarter were married, and the remainder were divorced or widowed. About two-thirds were abused by a father figure and over 40% reported multiple victimizations by different perpetrators during childhood. The most frequently reported method of abuse was fondling (85%), followed by

intercourse (57%), and fellatio (49%). For 23% of the sample, their victim experiences also included having been raped or gang-raped as adults.

Participants were assessed during the first and last sessions and again 6 months following termination of the group. Measures used to assess group members included a self-administered structured questionnaire, the Self-Assessment Scale (Roberts, 1987), the Group Dynamics Evaluation Scale (Roberts, 1987), and a client satisfaction questionnaire. A standard version of the BDI (Beck & Beamesderfer, 1974) was administered to the first five groups, while the short version BDI was used with Groups 6 to 9. The authors did not provide justification for changing instruments.

Nine groups with 5 to 6 members each met for 10 weekly sessions. The groups were led by two female therapists. Sessions included structured activities designed to promote group members' trust, self-awareness, understanding of issues related to incest, and reintegration of dissociated parts of themselves. It was unclear how many of the original participants completed the 10 group sessions and how many were included in the analyses of data.

Group participants reported improved psychosocial, physical, and sexual functioning over the course of the intervention as measured by the Self-Assessment Scale. The pretest-posttest differences in means on the BDI across groups was significant ($p < .01$). A total of 71.4% of group members experienced

decreased levels of depression from the pretest to posttest evaluation. The remainder were unchanged or reported more severe depressive symptoms.

Group members were sent a follow-up questionnaire 6 months after the end of group, and 21 of the 53 women responded. The overall magnitude of improvement at posttest appeared to vary within each of the 9 groups. Over the 6-month follow-up period the reduction in depression evidenced at posttest appeared to remain stable. The authors concluded that participants generally found the group environment conducive to their healing and development and were satisfied with the overall program.

Carver et al. (1989) also evaluated the effectiveness of a relatively unstructured, time-limited group therapy in reducing symptomatology of adult survivors of CSA. In addition, they examined characteristics of group members who completed treatment compared with those who dropped out.

A total of 95 women were assessed for possible participation in the group. Sixteen were considered inappropriate because they were thought disordered, currently abusing substances, had severe psychopathology, or had too recently disclosed their abuse for the first time. After the initial assessment, 11 women who were offered the opportunity to participate chose not to do so. Another 11 women were placed on a waiting list due to the unavailability of an additional group. The sample used in the study included the remaining 57 women.

Group members ranged in age from 18 to 64 ($\underline{M}$ = 29.8). Half of the women were single, 29% were married, and 21% were divorced or separated. Level of education varied with 42% never having completed high school, 33% having high school diplomas, and 25% earning college degrees. Less than 25% were unemployed; the remainder were either working, in school, or full-time homemakers. In terms of psychiatric treatment, 41% had been previously hospitalized, 63% had had previous therapy, and 47% were in current individual therapy. No information regarding abuse characteristics was provided.

Three measures were used to assess clients' symptomatology including the SCL-90-R (Derogatis, 1983), the Zung Self-Rating Depression Scale (Zung & Durham, 1965), and the Texas Social Behavior Inventory (TSBI; Helmreich & Stapp, 1974). These instruments were administered to all participants at the beginning and end of group. In addition, to assess for the effects of time alone, 20 participants completed the evaluation package at the time of their initial assessment. The average amount of time between initial assessment and the beginning of group was 7 weeks. During this time, participants did not receive any therapeutic intervention. No significant differences between assessment and pre-group test scores were found for any of the tests or subtests given. The authors, therefore, hypothesized that differences between pretest and posttest scores were likely due to the group therapy rather than just to the passage of time. All

participants who completed the group filled out an evaluation form at the conclusion of treatment.

Groups included in the study initially ran for 10 weeks (3 groups), but were later extended to 15 weeks (7 groups) based on the feedback from group members that they needed more time in group. The first group session was structured to provide a sense of security and to facilitate each member talking about sexual abuse from the outset. However, in subsequent groups sessions, the amount of input and structure which leaders provided varied depending upon the needs of the group. Some groups used aids such as films, art therapy, and childhood photographs to stimulate discussion and encourage disclosure of painful memories and feelings.

Significant differences between pretest and posttest scores were obtained on all of the SCL-90-R subtests, except paranoid ideation. There was not a significant increase in self-esteem as measured by the TSBI or decrease in level of depression on the Zung Self-Rating Depression Scale. However, scores on both of these measures changed in the expected direction. On the group evaluation form, 50% of the participants rated group as considerably helpful and 35% found it moderately helpful.

The above studies (Carver et al., 1989; Herman & Schatzow, 1984; Roberts & Lie, 1989) found that time-limited groups were generally beneficial to survivors

of CSA. Overall symptomatology as measured by the SCL-90-R was reduced and psychosocial, physical, and sexual functioning as measured by the Self-Assessment Scale improved. Enhanced self-esteem was found on the TSBI and reported by group members on evaluation forms. In addition, participants experienced a significant decrease in depression as measured by the BDI, and scores on the Zung Self-Rating Depression Scale approached significance in the desired direction.

Analysis of Yalom's Curative Factors

Three studies (Bonney et al., 1986; Randall, 1993; Wheeler, et al., 1992) compared and contrasted adult survivors' ratings of Yalom's (1975) curative factors to determine whether or not this population had a unique perspective about what is most helpful in therapy groups. These factors previously have been used in previous studies evaluating mechanisms of change in group therapy (Bloch, Crouch, & Reibstein, 1981; Butler, & Fuhriman, 1983; Marcovitz & Smith, 1983).

Yalom's (1975) groups consisted of 20 outpatients diagnosed as neurotic or character disordered who were considered successfully treated in a long-term, process-oriented group. He identified 12 therapeutic factors in the following order of importance: interpersonal learning (input), catharsis, cohesiveness, self-understanding, interpersonal learning (output), the existential factor, universality, instillation of hope, altruism, family reenactment, guidance, and identification.

Bonney et al. (1986) examined a group of adult survivors who participated in a long-term, open-ended group which used a psychodynamic interactional approach. The group was led by a male-female cotherapy team. The 7 women in the group were homogeneous regarding age (22 to 40), education (college), socioeconomic status (middle-class), and race (Caucasian). All were abused by father figures. No information regarding recruiting or exclusion criteria was provided.

Yalom's curative factors were analyzed using the Q-Sort method developed by Block (1961). This method involved having the participants sort 60 items representing the 12 curative factors into seven piles, ranging from most helpful to least helpful. Correlations were calculated among the sorts of the 7 group members. In addition, composite sorts were derived by ranking the total of the participants' placements for each item. Each of the cotherapists also sorted the items according to what he or she thought was most important for each group member's progress.

A correlation of .49 ($p < .01$) was obtained between the combined sorts of the incest group and Yalom's (1975) group of successful outpatients. In comparing the ranking of curative factors, Bonney et al. (1986) concluded that the most striking difference was the very high ranking accorded self-understanding and family reenactment (first and third, respectively) in the incest group, whereas with

Yalom's group these factors were ranked fourth and tenth, respectively. Interpersonal learning (input) was ranked highest by Yalom's group, but was only considered moderately important (seventh) by the incest survivors group.

Within group comparisons suggested that incest group members perceived the therapeutic experiences in a similar manner. When correlated with each other, group members' Q-Sorts produced 8 out of 21 significant correlations ($p < .01$). However, when therapists' Q-Sorts were compared with those of group members, only 3 out of 21 significant correlations emerged. The authors concluded that the therapists did not perceive the operation of the curative factors in the same manner as did group members.

Wheeler et al. (1992) conducted a study similar to that of Bonney et al. (1986) utilizing a closed, time-limited group for incest survivors. They compared their results to those of Yalom (1975) and Bonney et al. They also investigated whether or not the relative importance of the curative factors changed over the life of the group.

Group members were recruited through advertisements or referrals from their individual therapists at a university counseling center. They were screened to ensure that their level of functioning was appropriate to participate in group therapy. The group consisted of 7 women who had all experienced father-daughter incest as children. One member did not complete the treatment. Demographic

information about the participants was not provided. The group was based on a process-oriented model as described by Yalom (1975) and was cofacilitated by 2 experienced female therapists. The group met for 90 minutes weekly, for a total of 20 sessions.

This study employed the same Q-Sort method as described by Bonney et. al. (1986) which was administered during the week following group termination. In addition, the critical incident method developed by Bloch, Reibstein, Crouch, Holroyd, and Themen (1979) was employed to measure therapeutic factors over the life of the group. At the end of each session, group members completed a critical incident questionnaire. This involved responding to the following question: "What event (incident, interaction) from this session was most helpful to you? Describe what happened, the feelings you experienced, and how the event was helpful to you" (Wheeler et al., 1992, p. 91).

Three psychologists were trained in the method of classifying critical incidents developed by Bloch et al. (1979). Members statements of critical incidents from the group were classified into 10 therapeutic factors: self-disclosure, catharsis, interpersonal learning, universality, acceptance, altruism, guidance, self-understanding, vicarious learning, and instillation of hope. The percentages of agreement for the three pairs of raters were 73%, 84%, and 88%, suggesting good interrater reliability.

The results of this study indicate that the ranking of curative factors in Wheeler et al.'s (1992) group was more similar to Yalom's (1975) group than to Bonney et al.'s (1986) group. A correlation of .78 was obtained between this group's and Yalom's (1975) group's composite scores. A correlation of .55 was obtained between the combined sorts of this time-limited incest group and Bonney et al.'s (1986) long-term incest group.

The composite sorts of the Wheeler et. al. (1992) group revealed the following curative factors as receiving the highest respective rankings: catharsis, self-understanding, the existential factor, and cohesiveness. A comparison of the highest ranked therapeutic factors with Yalom's (1975) group indicated that the current group ranked the existential factor higher and interpersonal learning lower than Yalom's group. Unlike Bonney et al.'s (1986) incest survivors, the present group did not include family reenactment in the highest ranked factors. The presence of the existential factor in the current group's top ranked factors also differed from Bonney et al.'s group.

The analysis of the critical incident questionnaires revealed that in the early sessions (1 to 10) self-understanding, vicarious learning, acceptance, and self-disclosure received the highest rankings. In the late sessions (11 to 20) self-understanding, catharsis, self-disclosure, vicarious learning (tie), and acceptance (tie) were ranked highest. Catharsis was ranked high in later sessions,

but not in early sessions, which indicates that it may become more important later in the treatment process for incest survivors.

The most recent study evaluating curative factors was conducted by Randall (1993), and included participants from several therapy groups. Similar to the Bonney et al. (1986) study, Randall examined therapists' perceptions of what the group members experienced as most helpful in their group treatment. However, rather than using the Q-Sort method, Randall had each therapist rank the curative factors for the group as a whole on a Likert-type scale.

Randall (1993) studied 32 adult female incest survivors from nine survivor groups in private practice outpatient settings. Some groups were led by a single therapist (female), some had a female-female cotherapy team, and one group had a male-female cotherapy team. The groups met for a minimum of 6 months and all were considered to be long-term groups. Although therapy models varied, all leaders were experienced in leading incest survivors groups. Four group leaders described their clinical orientation as systemic, three described themselves as eclectic, and four described themselves as existential.

The composite sorts of Randall's (1993) group revealed the following curative factors as receiving the highest respective rankings: cohesiveness, self-understanding, family reenactment, and the existential factor. A comparison of the highest ranked therapeutic factors with Yalom's (1975) group indicated that

both ranked cohesiveness and self-understanding in the top four. However, Randall's group also highly valued family reenactment and the existential factor, whereas Yalom's group viewed interpersonal learning (input) and catharsis as most important. The current group diverged more from Yalom's group than from either Bonney et al.'s (1986) or Wheeler et al.'s (1992) groups.

In a subsequent article, Randall (1995) compared results of his 1993 study to those of the two other incest survivor group studies (Bonney et al., 1986; Wheeler et al. 1992). Cohesiveness and self-understanding were highly valued by all three groups. The two long-term survivor groups viewed family reenactment as important, but the time-limited group ranked it ninth. Randall (1995) suggested that it is possible that family reenactment may not emerge until later in the life of an incest survivor group. In time-limited groups, members may not have the opportunity to develop the transference that Bonney et al. suggested could be responsible for the high rating of family reenactment in their group. Another possibility is that the orientation of the therapists in the long-term groups may have led to more focus on family issues and genetic insight.

Both Randall's (1993) and Wheeler et al.'s (1992) groups placed the existential factor in the top ranking, but Bonney et al.'s (1986) group ranked it only moderately important. Randall (1995) suggested that because Bonney et al.'s study reported on a group experience that occurred fairly early in the incest

recovery movement, the results may reflect more despair and a sense of being overwhelmed among the survivors. This may have contributed to their lower ranking of hope and the existential factor. The one similarity across all groups is found at the bottom of the ranking. Altruism, guidance and identification are consistently ranked low. This similarity may have implications for learning what group members are not looking for in a group experience.

Randall (1993) and Bonney et al. (1986) both found that therapists viewed curative factors differently than did their group members. Therapists and group members essentially agreed that self-understanding and cohesiveness were important, but they had major differences concerning family reenactment. The therapists placed family reenactment last and their clients placed it first.

Evaluation of Specific Aspects of Group Interventions

The studies which have been reviewed thus far have focused on client characteristics which affect outcome, time-limited group treatment in general, and clients' perceptions about what is curative or therapeutic in the context of group treatment. The literature on group treatment also includes one empirical study which investigated the effect of therapist's gender on treatment outcome for incest survivors, as well as two studies which examined specific types of interventions.

Threadcraft and Wilcoxon (1993) investigated the effect of using a mixed gender cotherapy team in a group for adult survivors of CSA. They specifically

examined whether or not improvements in depression and self-concept scores would be similar to those obtained in a group with female cotherapists.

Participants were self-referred or referred by a mental health professional. Women were screened from group admittance if they posed a danger to self or others, were in an emotional crisis, were in treatment for a psychiatric disorder, or were in individual therapy with a counselor who opposed their participation. Those who reported abuse of controlled or illegal substances or abuse of their own children were also excluded.

Ten women were selected to participate in this time-limited group. They ranged in age from 23 to 41 years and varied in race, educational background, religious preference, and marital status. Specific demographic information was not provided. Only 7 of the 10 women completed treatment.

The revised BDI (Beck & Steer, 1984) was used to assess participants' level of depression; the Adult Self-Perception Profile (ASPP; Messer & Harter, 1986) was used to assess self-concept. These measures were administered during the screening interview and at the end of the final group therapy session.

This study used the group therapy model developed by Apolinsky (1990) for counseling adult survivors of childhood sexual victimization. The model reflects a structured 10-session group therapy program, with both cognitive and

affective-experiential components. Both the male and female facilitators were trained in the application of Apolinsky's model prior to the beginning of group.

The results indicated that there was a significant positive increase in self-concept as measure by the ASPP for group members from pretest to posttest. There was also a significant decrease in depression as measured by the BDI. These results were similar to those obtained by Apolinsky and Wilcoxon (1991) using a female cotherapy team. The authors suggested that mixed gender leadership may not be contraindicated in treating adult survivors and may even promote positive outcomes.

Apolinsky and Wilcoxon (1991) investigated the comparative effects of symbolic confrontation of the abuser on measures of self-concept and depression in adult survivors of CSA participating in group therapy. For purposes of this study, adult survivor was defined as "any woman claiming victimization and experiencing subsequent emotional difficulties as an adult related to the abuse experiences" (p. 86).

Group members were evaluated for participation during a screening interview. Clients for whom group services were contraindicated were those who: (a) were in a state of extreme crisis, (b) were actively abusing chemical substances, (c) were abusing their children at the time of screening, (d) were exhibiting symptoms and or had been diagnosed as psychotic, or (e) were a danger to

themselves or others. In addition, participants were required to demonstrate motivation for participation in the group and an ability and willingness to engage in a dialogue regarding their victimization experiences.

The sample included 30 Caucasian women who ranged in age from 18 to 64 (Mdn = 37). Marital status of participants was married (34%), divorced or separated (29%), single (20%), and other (17%). More than half of the participants were college graduates and only one group member did not have a high school diploma. Half of the women were employed full time, 21% worked part time, and 29% were not employed.

The revised BDI was used to assess the severity of depression in the participants; the ASPP was used to assess self-concept. These were administered during the screening interview and at the end of the final group therapy session.

Group participants were randomly assigned to one of two groups which met for ten 2-hour sessions. The same female coleaders were used for both groups. Session topics and formats were consistent for both groups with two exceptions. In the experimental condition, Session 8 included group members reading a letter (which would not be mailed) to their offender. Session 9 featured the use of the empty-chair technique (Perls, Hefferline, & Goodman, 1951) with the offender in the group context. All participants in both groups completed the 10-week intervention.

No significant pretreatment differences between the control and intervention groups were found on level of depression (BDI) or self-concept (ASPP). By contrast, at posttreatment, statistically significant differences between groups were found on both measures. Pretreatment and posttreatment comparisons were also calculated within the two groups. Statistically significant differences on the BDI and ASPP were found for the experimental group but not for the control group.

The authors concluded that the use of symbolic confrontation within the context of this structured group intervention program was statistically significant in increasing group members' self-concept and in decreasing their level of depression. The fact that these differences were noted within the experimental but not the control group suggested that the combination of the structured group modality and the technique of symbolic confrontation was critical to these results. This study provides some empirical support for the use of symbolic confrontation in working with adult survivors of CSA.

Alexander et al. (1989) conducted the only controlled study to date evaluating the therapeutic impact of two different group therapy formats. They compared the effectiveness of a specialized group format and a less structured interpersonal process group format with a wait list control condition.

Participants were 65 women who had been recruited through newspaper advertisement. They were not in concurrent individual therapy during the course of treatment or the wait list period. Exclusion criteria included serious suicidal ideation, psychosis, and severe substance abuse.

The group members ranged in age from 23 to 55 years ($\underline{M}$ = 36). The mean number of years of education was 13.7 years with a range of 2 to 21 years. Marital status was 39% single, 36% married, and 20% divorced. The racial composition of the sample was 76% Caucasian and 24% African-American.

With respect to the incestuous experience, the mean length of abuse was 7 years with a range of 1 month to 16 years. For one third of the women, the abuse began before the age of 6 years, for half of the women the abuse began when they were from 6 to 11 years old, and for the remainder of the group onset occurred during adolescence. With respect to the type of sexual abuse experienced, one third experienced fondling only, 15% experienced oral/genital contact, and over half experienced sexual intercourse. The natural father was the perpetrator for 40 women, while 19 were abused by a stepfather and 6 by another male relative.

Four measures were used to assess group member functioning. These included the BDI, Social Adjustment Scale (SAS), SCL-90-R, and Modified Fear Survey (MFS). The instruments were administered before the beginning of group and at the end of group or approximately 12 weeks later for the wait list condition.

After the second evaluation, individuals in the wait list condition were offered the opportunity to participate in a group and were not included in any subsequent evaluation. Women who had participated in the two group treatments were evaluated 6 months following the termination of group.

After completing the assessment instruments, participants were randomly assigned to either the wait list condition, the interpersonal transaction (IT) group condition, or the process group condition. Four groups were conducted in each of the two group formats, for a total of eight therapy groups. Four advanced female doctoral students in clinical psychology served as cotherapists. Each cotherapy team conducted groups in both treatment conditions to control for differential competence and match between the two leaders and the group format. Groups met for 90 minutes each week for 10 weeks.

In the IT format, the therapists introduced a new dyadic disclosure topic related to the experience of incest each week. After the topic was introduced, group members split into pairs to discuss the topic for 4 minutes, after which they rotated to a new partner. Emphasis was placed on the nonjudgmental sharing of common experiences and feelings relevant to incest and to the family experience. Following the dyadic discussions, the therapists asked bridging questions to facilitate discussions about similarities and differences in experiences.

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The structure of the process group format followed the guidelines provided by Courtois (1988). In the first few sessions, group members shared their goals and expectations, as well as their incest experiences. Subsequent groups focused on each member's actual interactions with the group as a means of developing a new perspective on incest, of understanding problematic interpersonal behaviors, and of experimenting with new ways of relating to the group and people in general. The actual topics covered in each session were left to the discretion of the group members.

A total of 7 women failed to complete treatment. These women did not differ significantly from those who completed group with respect to age, education, marital status, or race. They also did not differ significantly from group completers in abuse characteristics or on the BDI, SAS, or SCL-90-R. However, they reported significantly less fearfulness on the MFS at the initial evaluation ($p < .05$).

Analyses of data indicate that there were no significant main effects for treatment type and no significant effect for groups within treatment type. However, the main effect for time was significant ($p < .001$) and the interaction effect of Treatment x Time was also significant ($p < .05$). Participants in the two treatment groups showed a significant improvement from pretreatment to posttreatment in their experience of depression ($p < .001$) and general distress ($p < .05$), in contrast

to those in the wait list condition who showed no change. On the other hand, only subjects in the process group exhibited improvement in their social adjustment ($p < .05$) as measured by the SAS, whereas subjects in the wait list condition actually deteriorated ($p < .01$). Individuals in the IT groups showed a nonsignificant trend toward improvement on the SAS ($p < .11$).

Comparisons of adjustment were also made between the IT group and the process group condition at pretreatment, posttreatment, and 6-month follow-up. There was a significant effect of time; all other main effects and interactions were not significant. A comparison of means suggested not only that improvement on the BDI, the SAS, the MFS, and the SCL-90-R was maintained at 6-month follow-up in both the IT and process groups, but that participants continued to improve. Alexander et al. (1989) concluded that both group formats were equally successful in assuring maintenance of treatment gains.

The three studies reviewed in this section evaluated the effect of a mixed gender cotherapy team, a specific intervention (symbolic confrontation), and two group formats in treating adult survivors of CSA. They all reported that group members improved in terms of level of depression, self-concept, social adjustment and overall distress. Alexander et al. (1989) and Apolinsky and Wilcoxon (1991) represent the first empirical research using a control group design which provides support for the efficacy of group treatment for adult survivors of CSA.

Clinical Implications

Although the empirical research on group treatment of adult survivors of CSA is limited, this body of literature does add to our understanding of factors affecting survivors' adaptation to sexual abuse as well as their response to group therapy. The research provides some initial guidance and suggestions for addressing the treatment needs of this important population. Clinical implications of the research will be discussed related to client characteristics, time-limited groups, and curative factors.

Client Characteristics

Results from studies that evaluated the affect of client characteristics on treatment completion and outcome suggest several factors that are important to consider in group member selection. Carver et al. (1989) and Hazzard et al. (1993) found that previous psychiatric hospitalization was associated with failure to complete group. Although other studies did not find this strong relationship (Fisher et al., 1993), it still may be helpful for group leaders to question survivors about prior hospitalizations in screening interviews. Because too many dropouts can potentially destroy group trust and cohesion, group leaders may want to limit the number of group members who previously have been hospitalized.

The association of greater change with group member similarity in abuse history found by Hazzard et al. (1993) indicates that perceived similarity among

group members may be an important component to consider in forming treatment groups. Hazzard et al. also suggested that better outcome for Caucasian than ethnic minority group members in this study may actually relate to the similarity variable, given that 92% of group members and all of the therapists were Caucasian. These findings support Courtois' (1988) caution against forming groups with isolates. It is important for group leaders to try to ensure that no member is strikingly different from the other members in terms of variables such as ethnicity and abuse history.

Issues related to trust and being taken advantage of have been identified as prominent and enduring for sexual abuse survivors. This observation appears to be supported by the empirical literature reviewed. Fisher et al. (1993) found that incest survivors had higher elevations on the paranoid-delusion scale of the MCMI than is typically found among psychiatric populations. Carver et al. (1989) reported that the paranoid subscale of the SCL-90-R was the only subscale not to improve significantly over the course of group therapy. Given these results, it would seem imperative for group therapists to recognize the importance of trust and safety for survivors of CSA and to address those issues for an extended part of the group.

There seems to be an association between marital status and response to treatment. Fisher et al. (1993) and Follette et al. (1991) both found that survivors who were married were more likely to drop out of treatment. Fisher et al. attributed this finding to the high number of married participants who were currently in

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abusive relationships. Follette et al. also found that lower marital satisfaction scores were associated with increasing pretreatment maladjustment and poorer response to therapy. Couples therapy either prior to or in conjunction with group treatment may be useful for women in ongoing relationships who are also in treatment for dealing with the effects of sexual abuse.

Time-Limited Groups

All of the studies evaluating time-limited groups reported significant improvement for group members over the course of therapy. Changes included decreased depression (Alexander et al., 1989; Apolinsky & Wilcoxon, 1991; Roberts & Lie, 1989; Threadcraft & Wilcoxon, 1993), enhanced self-esteem (Apolinsky & Wilcoxon, 1991; Hazzard et al., 1993; Threadcraft & Wilcoxon, 1993), and reduced overall symptomatology (Carver et al., 1989; Hazzard et al., 1993; Roberts & Lie, 1989). These results suggest that time-limited groups can be an effective component of treatment for survivors of CSA.

In general, improvement for group members occurred regardless of the specific format used. Some groups utilized a very structured approach (Apolinsky & Wilcoxon, 1993; Herman & Schatzow, 1984) but varied in the types of activities they used (e.g., films, photos, guided imagery, psychodrama, and journal assignments). Others allowed group members to determine the content of each session (Carver et al., 1989). There was also great variety in the types of activities

used in structured groups. In the only empirical comparison of two group formats, Alexander et al. (1989) found that both a structured group and a relatively unstructured group were effective relative to the wait list condition in reducing depression and alleviating distress. One possible conclusion is that the experience of being in a group with other survivors is in and of itself therapeutic and that the format of the group is not an important issue.

Gender of the cotherapy team also did not appear to affect therapeutic outcome. Hazzard et al. (1989) found that the number of members who dropped out of groups led by two women and those facilitated by a male-female team did not significantly differ. In addition, similar improvement was reported in a group led by a mixed gender cotherapy team (Threadcraft & Wilcoxon, 1993) as was obtained in groups cofacilitated by women (Apolinsky & Wilcoxon, 1993).

Although time-limited group treatment led to improvement for group members as a whole, none of the authors suggested that it was necessarily sufficient to ameliorate the long-term effects of CSA. In fact, only one study (Fisher et al., 1993) addressed the clinical significance of the improvement obtained on various assessment instruments. Addressing the clinical range of scores is especially important in outcome research because statistically significant changes do not necessarily translate directly into clinically significant

improvement. This issue needs to be corrected in the reporting of future research results.

Curative Factors

It appears that curative factors do hold different levels of importance for groups with various therapeutic needs. Incest group members apparently perceived the therapeutic experience similarly to each other, but ranked the curative factors differently than did participants in most other studies using the same instrument (Rohrbaugh & Bartels, 1975; Sherry & Hurley, 1976). The high degree of similarity in presenting problems may account for much of this difference. However, in light of these results, it seems prudent that group leaders focus on the curative factors ranked higher by this specific population when structuring groups.

Cohesiveness and self-understanding were important to all groups (Bonney et al., 1986; Randall, 1993; Wheeler et al., 1992; Yalom, 1975). Cohesiveness contains the personal values associated with trust, belonging, and connectedness, and may form the foundation for the operation of many of the other factors (Randall, 1995). Group leaders may find it helpful to encourage self-reflection on the incest experience and its impact on survivors' lives. This process can help survivors find meaning and place this experience in the perspective of their lives as a whole. However, Randall (1995) recommended that leaders of any specialty

group should not become so focused on the group theme that they lose sight of the foundational aspects of solid group dynamics.

According to Bonney et al. (1986), genetic insight (family reenactment) is a curative factor that may be pivotal to the success of some of the other factors. This may be particularly true if both therapist and client perceive present adjustment difficulties as originating in childhood, which is more typical with incest than for many other presenting problems. The fact that family reenactment was highly valued by the two long-term survivor groups (Bonney et al., 1986; Randall, 1993), but not by the time-limited group (Wheeler et al., 1992), suggests that working through family of origin issues may require a prolonged group experience.

The incest groups' consistently low ranking of identification, guidance, altruism, and interpersonal learning strongly suggests that incest survivors view their group participation from a self-absorbed perspective. Clinicians may do well to accept this egocentric view and work gradually to move survivors toward a more balanced view of themselves in relationships. Concern for others may only come after successfully resolving their own issues of self-understanding and family reenactment.

Finally, group leaders may need to admit that their clinical perceptions do not agree with their clients' perceptions of which curative factors are most helpful (Randall, 1993; Wheeler et al., 1992). Group leaders might serve their groups by

periodically seeking the members' perceptions of what they find helpful, either through testing or focused discussion.

Future Research

The majority of research on group treatment of adult survivors of CSA used either small and/or very nonrepresentative samples. Studies using larger samples which include individuals of diverse ethnic minority groups with varied socioeconomic backgrounds would increase the applicability of results. Research on treatment of male survivors is also long overdue.

Results of the studies reviewed reflect the outcome of treatment with carefully screened participants. Further research is needed to develop models of group treatment that might be suitable for a less carefully selected patient population. This is particularly important given the high incidence of sexual abuse history among psychiatric patients.

Investigation into specific aspects of group treatment could help refine group therapy approaches for sexual abuse survivors. Interesting areas to examine might include how specific therapeutic techniques, treatment length, open or closed format, gender of therapists, number of therapists, and group member similarity affect treatment outcome.

The relative contribution of individual and group therapy to successful treatment outcome needs to be evaluated. This would help delineate the complementary roles of group and individual therapy for adult survivors. In addition, further follow-up research needs to assess whether or not individual therapy is required to maintain improvement obtained during group treatment and whether gains are retained over the long-term.

Finally, more carefully controlled studies need to be conducted with this population. All of the studies reviewed, except Alexander et al. (1989) and Apolinsky and Wilcoxon (1991), had substantial potential for intervening variables to affect the results. Improved research design is needed to better identify the contribution of group intervention to treatment outcome.

REFERENCES

Agosta, C., & Loring, M. (1988). Understanding and treating the adult retrospective victim of child sexual abuse. In S. M. Sgroi (Ed.), Vulnerable populations: Vol. 1. Evaluation and treatment of sexually abused children and adult survivors (pp. 115-136). Lexington, MA: Lexington Books.

Alexander, P. C., & Follette, V. M. (1987). Personal constructs in the group treatment of incest. In R. A. Neimeyer, & G. J. Neimeyer (Eds.), Personal construct therapy casebook (pp. 211-229). New York: Springer Publishing.

Alexander, P. C., Neimeyer, R. A., Follette, V. M., Moore, M. K., & Harter, S. (1989). A comparison of group treatments of women sexually abused as children. Journal of Consulting and Clinical Psychology, 57, 479-483.

Apolinsky, S. R. (1990). Symbolic confrontation as a counseling technique to enhance self concept and decrease depression for adult survivors of CSA. Unpublished doctoral dissertation. The University of Alabama, Tuscaloosa.

Apolinsky, S. R., & Wilcoxon, S. A. (1991). Symbolic Confrontation with women survivors of childhood sexual victimization. The Journal for Specialists in Group Work, 16, 85-90.

Barney, E. E. (1990). A clinical practice model for treatment of college-aged incest survivors. Journal of American College Health, 38, 279-283.

Beck, A. T., & Beamesderfer, A. (1974). Assessment of depression: The Depression Inventory. In P. Pichot, (Ed.), Psychological measurements in psychopharmacology(Vol. 7): Modern problems in pharmacopsychiatry, (pp. 151-169). Basel: Karger.

Beck, A. T., & Steer, R. A. (1984). Internal consistencies of the original and revised Beck Depression Inventory. Journal of Clinical Psychology, 40, 1365-1367.

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. Clinical Psychology Review, 8, 77-100.

Beitchman, J. H., Zucker, K. J., Hood, J. E., Granville, A. D., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. Child Abuse & Neglect, 16, 101-118.

Bendixen, M., Muus, K. M., & Schei, B. (1994). The impact of child sexual abuse: A study of a random sample of Norwegian students. Child Abuse & Neglect, 18, 837-847.

Beutler, L. E., & Hill, C. E. (1992). Process and outcome research in the treatment of CSA: Methodological issues. Journal of Consulting and Clinical Psychology, 60, 204-212.

Bloch, S., Crouch, E., & Reibstein, J. (1981). Therapeutic factors in group psychotherapy: A review. Archives of General Psychiatry, 38, 519-526.

Bloch, S., Reibstein, J., Crouch, E., Holroyd, P., & Themen, J. (1979). A method for the study of therapeutic factors in group psychotherapy. British Journal of Psychiatry, 134, 257-263.

Block, J. (1961). The Q-Sort method in personality assessment and psychiatric research. Springfield, IL: Thomas.

Bonney, W. C., Randall, D. A., & Cleveland, J. D. (1986). An analysis of client-perceived curative factors in a therapy group of former incest victims. Small Group Behavior, 17, 303-321.

Briere, J., Evans, D., Runtz, M., & Wall, T. (1988). Symptomology in men who were molested as children: A comparison study. American Journal of Orthopsychiatry, 58, 457-461.

Briere, J., & Runtz, M. (1988). Symptomatology associated with childhood sexual victimization in a nonclinical adult sample. Child Abuse & Neglect, 12, 51-59.

Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. Journal of Interpersonal Violence, 4, 151-163.

Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. Psychological Bulletin, 99, 66-77.

Bryer, J. B., Nelson, B. A., & Miller, J. B. (1987). Childhood, sexual and physical abuse as factors in adult psychiatric illness. American Journal of Psychiatry, 144, 1426-1430.

Butler, T., & Fuhriman, A. (1983). Curative factors in group therapy: A review of the recent literature. Small Group Behavior, 14, 131-142.

Cahill, C., Llewelyn, S. P., & Pearson, C. (1991). Long-term effects of sexual abuse which occurred in childhood: A review. British Journal of Clinical Psychology, 30, 117-130.

Carmen, E. H., Rieker, P. P., & Mills, T. (1984). Victims of violence and psychiatric illness. American Journal of Psychiatry, 141, 378-383.

Carver, C. M., Stalker, C., Stewart, E., & Abraham, B. (1989). The impact of group therapy for adult survivors of CSA. Canadian Journal of Psychiatry, 34, 753-758.

Cole, C. H., & Barney, E. E. (1987). Safeguards and the therapeutic window: A group treatment strategy for adult incest survivors. American Journal of Orthopsychiatry, 57, 601-609.

Courtois, C. A. (1988). Healing the incest wound. New York: W. W. Norton.

Deighton, J. & McPeek, P. (1985). Group treatment: Adult victims of childhood sexual abuse. Social Casework, 66, 403-410.

Den Herder, D., & Redner, L. (1991). The treatment of childhood sexual trauma in chronically mentally ill adults. Health and Social Work, 16, 50-56.

Derogatis, L. R. (1983). The SCL-90-R manual II: Administration, scoring and procedures. Towsor, MD: Clinical Psychometric Research.

DiTomasso, M. J., & Routh, D. K. (1993). Recall of abuse in childhood and three measures of dissociation. Child Abuse & Neglect, 17, 477-485.

Draucker, C. B. (1992). Construing benefit from a negative experience of incest. Western Journal of Nursing Research, 14, 343-357.

Finkelhor, D. (1979). Sexually victimized children. New York: Free Press.

Finkelhor, D. (1984). Child sexual abuse: New theory and research. New York: Free Press.

Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. Professional Psychology: Research and Practice, 21, 325-330.

Finkelhor, D., Hotaling, G. T., Lewis, I. A., & Smith, C. (1989). Sexual abuse and its relationship to later sexual satisfaction, marital status, religion, and attitudes. Journal of Interpersonal Violence, 4, 379-399.

Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. Child Abuse & Neglect, 14, 19-28.

Fisher, P. M., Winne, P. H., & Ley, R. G. (1993). Group therapy for adult women survivors of child sexual abuse: Differentiation of completers versus dropouts. Psychotherapy, 30, 616-623.

Follette, V. M., Alexander, P. C., & Follette, W. C. (1991). Individual predictors of outcome in group treatment for incest survivors. Journal of Consulting and Clinical Psychology, 59, 150-155.

Forward, S., & Buck, C. (1978). Betrayal of innocence: Incest and its devastations. New York: Penguin.

Gil, E. (1988). Treatment of adult survivors of childhood abuse. Walnut Creek, CA: Launch Press.

Gold, S. R. (1991). History of child sexual abuse and adult sexual fantasies. Violence and Victims, 6, 75-82.

Goodman, B., & Nowak-Scibelli, D. N. (1985). Group treatment for women incestuously abused as children. The International Journal of Group Psychotherapy, 35, 531-544.

Green, A. H. (1993). Child sexual abuse: Immediate and long-term effects and intervention. Journal of the American Academy of Child and Adolescent Psychiatry, 32, 890-902.

Hall, Z. M. (1992). Group therapy for women survivors of CSA. Group Analysis, 25, 463-475.

Hazzard, A., Rogers, J. H., & Angert, L. (1993). Factors affecting group therapy outcome for adult sexual abuse survivors. The International Journal of Group Psychotherapy, 43, 453-468.

Helmreich, R., & Stapp, J. (1974). Short forms of the Texas Social Behavior Inventory (TSBI): An objective measure of self esteem. Bulletin of the Psychonomic Society, 4, 473-475.

Herman, J., & Schatzow, E. (1984). Time-limited group therapy for women with a history of incest. International Journal of Group Psychotherapy, 34, 605-616.

Hudson, W. (1982). The clinical measurement package: A field manual. Chicago: Dorsey.

Hunter, J. (1991). A comparison of the psychosocial maladjustment of adult males and females sexually molested as children. Journal of Interpersonal Violence, 6, 205-217.

Hutchings, P. S., & Dutton, M. A. (1993). Brief Report: Sexual assault history in a community mental health center clinical population. Community Mental Health Journal, 29, 59-63.

Jacobson, N. S., Follette, W. C., & Revenstorf, D. (1984). Psychotherapy outcome research: Methods for reporting variability and evaluating clinical significance. Behavior Therapy, 15, 336-352.

Jehu, D. (1988). Beyond sexual abuse: Therapy with women who were childhood victims. New York: Wiley.

Knight, C. (1993). The use of a therapy group for adult men and women sexually abused in childhood. Social Work with Groups, 16, 81-94.

Kreidler, M. C., & Fluharty, L. B. (1994). The "New Family" model: The evolution of group treatment for adult survivors of CSA. The Journal for Specialists in Group Work, 19, 175-181.

Levinson, D., & Huffman, P. (1955). Traditional family ideology and its relation to personality. Journal of Personality, 23, 251-273.

Locke, H. J., & Wallace, K. M. (1959). Short marital-adjustment and prediction tests: Their reliability and validity. Marriage and Family Living, 21, 251-255.

Maltz, W., & Holman, B. (1987). Incest and sexuality: A guide to understanding and healing. Lexington: Health.

Marcovitz, R. J., & Smith, J. E. (1983). Patients' perceptions of curative factors in short-term group psychotherapy. International Journal of Group Psychotherapy, 33, 21-39.

McEvoy, M. (1990). Repairing personal boundaries: Group therapy with survivors of sexual abuse. In T. A. Laidlaw, C. Malmo, & Associates, Healing voices: Feminist approaches to therapy with women (pp. 62-79). San Francisco: Jossey-Bass.

Mennen, F. E., & Meadow, D. (1992). Process to recovery: In support of long-term groups for sexual abuse survivors. International Journal of Group Psychotherapy, 42, 29-44.

Messer, B., & Harter, S. (1986). Adult self-perception profile. Denver, CO: University of Denver.

Millon, T. (1983). Million Clinical Multiaxial Inventory Manual (3rd ed.). Minneapolis, MN: Interpretive Scoring System.

Nowicki, S., & Duke, M. P. (1974). The locus of control scale for college as well as non-college adults. Journal of Personality Assessment, 38, 136-137.

Olson, D. H., Russell, C. S., & Sprenkle, D. H. (1983). Circumplex model of marital and family systems: Theoretical update. Family Process, 22, 69-83.

Perls, F., Hefferline, R. F., & Goodman, P. (1951). Gestalt therapy. New York: Bantam Books.

BEST COPY AVAILABLE

Randall, D. A. (1993). An analysis of curative factor rankings and attendant critical conditions for adult female incest groups (Doctoral dissertation, The University of Georgia, 1992). Dissertation Abstracts International, 53, B5435.

Randall, D. A. (1995). Curative factor rankings for female incest survivor groups: A summary of three studies. The Journal for Specialists in Group Work, 20, 232-239.

Roberts, L. (1987). A treatment manual for therapy groups with survivors of childhood incest. Madison, WI: Rape Crisis Center.

Roberts, L., & Lie, G. Y. (1989). A group therapy approach to the treatment of incest. Social Work with Groups, 12, 77-90.

Roesler, T. A., & McKenzie, N. (1994). Effects of childhood trauma on psychological functioning in adults sexually abused as children. Journal of Nervous and Mental Disease, 182, 145-150.

Rohbaugh, M., & Bartels, B. D. (1975). Participants' perceptions of "curative factors" in therapy and growth groups. Small Group Behavior, 6, 430-456.

Runtz, M., & Briere, J. (1986). Adolescent "acting out" and childhood history of sexual abuse. Journal of Interpersonal Violence, 1, 326-333.

Russell, D. E. H. (1986). The secret trauma: Incest in the lives of girls and women. New York: Basic Books.

Schwartz, M. (1975). Situation/transition groups: A conceptualization and review. American Journal of Orthopsychiatry, 45, 744-755.

Sgroi, S. M., & Bunk, B. S. (1988). A clinical approach to adult survivors of child sexual abuse. In S. M. Sgroi (Ed.), Vulnerable populations: Vol. 1. Evaluation and treatment of sexually abused children and adult survivors (pp. 137-186). Lexington, MA: Lexington Books.

Sherry, P., & Hurley, J. R. (1976). Curative factors in psychotherapeutic and growth groups. Journal of Clinical Psychology, 32, 835-837.

Sherry, P., & Hurley, J. R. (1976). Curative factors in psychotherapeutic and growth groups. Journal of Clinical Psychology, 32, 835-837.

Stein, J. A., Golding, J. M., Siegel, J. M., Burnam, M. A., & Sorenson, S. B. (1988). Long-term psychological sequelae of child sexual abuse: The Los Angeles Epidemiologic Catchment Area Study. In G. E. Wyatt & G. J. Powell (Eds.), Lasting effects of child sexual abuse (pp. 135-154). Newbury Park, CA: Sage.

Threadcraft, H. L., & Wilcoxon, S. A. (1993). Mixed-gender group co-leadership in group counseling with female adult survivors of childhood sexual victimization. The Journal for Specialists in Group Work, 18, 40-44.

Veronen, L. J., & Kilpatrick, D. G. (1980). Reported fears of rape victims: A preliminary investigation. Behavior Modification, 4, 383-396.

Weissman, M. M., & Paykel, E. S. (1974). The depressed woman. Chicago: University of Chicago Press.

Wheeler, I., O'Malley, K., Waldo, M., Murphy, J., & Blank, C. (1992). Participants' perception of therapeutic factors in groups for incest survivors. The Journal for Specialists in Group Work, 17, 89-95.

Yalom, I. D. (1975). The theory and practice of group psychotherapy. New York: Basic Books.

Zung, W. W. K., & Durham, N. C. (1965). A self-rating depression scale. Archives of General Psychiatry, 12, 63-70.

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